



1199SEIU

**Greater New York Benefit Fund
for New Jersey Area Members**

IMPORTANT PHONE NUMBERS

**Benefit Fund's
Member Services
Department**
(646) 473-9200

**Aetna Member Services
Department**
(866) 658-2455

**Cigna Member Services
Department**
(800) 244-6224 (CIGNA24)

DISCLAIMER

This document is not the official Summary Plan Description (SPD) of the 1199SEIU Greater New York Benefit Fund for New Jersey Area Members. Please consult the SPD for a full description of your Fund benefits. In case of any conflict between this document and the SPD, the terms of the SPD shall govern.

Members can request a Summary Plan Description (SPD) by calling the Member Services Department at (646) 473-9200. Outside New York City area codes, call (800) 575-7771. Westchester and upstate counties, call (877) 557-1199. The SPD is also available on the Fund's website at www.1199SEIUBenefits.org.



**1199SEIU GREATER NEW YORK BENEFIT FUND
for New Jersey Area Members**

330 West 42nd Street

New York, NY 10036-6977

(646) 473-9200

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MARCH 2012



Overview of Your Benefits

COVERAGE**IN-NETWORK BENEFITS ONLY****Deductible (per contract year)**

Once Family Deductible is met, all family members will be considered as having met their deductible for the remainder of the contract year.

Member Coinsurance

Applies to all expenses unless otherwise stated

Payment Limit (per contract year)

Certain member cost-sharing elements may not apply toward the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the contract year.

Contract Year Maximum**Primary Care Physician Selection****Referral Requirement**

- \$225 per individual/\$450 per family
- Covered 85%
- \$800 per individual/\$1,600 per family (excludes deductible)
- \$50,000 per member increasing to \$75,000 per member effective January 1, 2012
- Optional
- None

PREVENTIVE CARE**Routine Adult Physical Exams/Immunizations**

1 exam per 12 months for members over age 18

Routine Well-Child Exams/Immunizations**Routine Gynecological Care Exams**

2 exams per 12 months. Includes routine tests and related lab fees.

Routine Mammograms

1 baseline between ages 35 to 39
1 per year for covered females age 40 and over

Routine Digital Rectal Exam/Prostate-specific Antigen Test

Covered 1 per 12 months for males age 40 and over

Colorectal Cancer Screening

For all members age 50 and over

Routine Hearing Exams

- 100% after office visit co-pay
- 100%
- 100% after \$10 office visit co-pay
- 100%
- 100%
- 100%
- Not Covered

COVERAGE**IN-NETWORK BENEFITS ONLY****PHYSICIAN SERVICES****Office Visits to Primary Care Practitioner (PCP)**

Includes services of an internist, general physician, family practitioner or pediatrician

Specialist Office Visits**Allergy Testing****Allergy Injection****Diagnostic Procedures**

If performed as part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost-sharing.

- \$10 office visit co-pay
- \$10 office visit co-pay
- Covered as either PCP or specialist visit
- \$10 office visit co-pay (Serum – no charge if dispensed in a doctor's office)
- Covered 85% after deductible is met

EMERGENCY MEDICAL CARE**Urgent Care Provider**

(benefit availability may vary by location)

Non-Urgent Use of Urgent Care Provider**Emergency Room****Non-Emergency Care in an Emergency Room****Ambulance**

- \$75
- Covered
- \$125 co-pay (waived if admitted)
- Not Covered
- Covered 85% after deductible is met

HOSPITAL CARE**Inpatient Coverage**

The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.

Inpatient Maternity Coverage

The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.

Outpatient Surgery**Outpatient Hospital Expenses (excluding surgery)**

The member cost-sharing applies to all Covered Benefits incurred during a member's outpatient visit.

- Covered 85% after deductible is met
- Covered 85% after deductible is met
- Covered 85% after deductible is met
- Covered 85% after deductible is met

COVERAGE

IN-NETWORK BENEFITS ONLY

The following dental benefits are provided by Cigna subject to co-payments and limitations as described. Other than in emergency situations, benefits are not provided for services rendered by a non-participating dentist.

DENTAL

Benefits provided for full-time members and their eligible dependents only, and Genesis employees and their eligible dependents based upon your family election.

- Each individual must select a Cigna dentist as their designated (or primary care) dentist.
- Other than for emergencies, services must be performed by your designated Cigna participating dentist.
- Referrals required for some specialists
- Co-payments and limitations may apply for some procedures, excluding essential oral pediatric services.
- No annual maximum

The following benefits are provided directly by the Benefit Fund:

PRESCRIPTION DRUGS

- FDA-approved prescription medications for FDA-approved indications, except plan exclusions
- \$10 co-pay for generic drugs and \$15 co-pay for preferred brand-name drugs
- Use Participating Pharmacies
- Maintenance drug access program for chronic conditions – *The 90-Day Rx Solution*
- Comply with the Benefit Fund's prescription programs, including prior authorization when required.
- Please refer to "What Is Not Covered" in Section II.L.
- For a complete list of these programs, call the Benefit Fund at (646) 473-9200 or visit www.1199SEIUBenefits.org.
- Please note "What Is Not Covered" in Section VII.

COVERAGE

IN-NETWORK BENEFITS ONLY

DISABILITY BENEFITS

Member-Only Benefit

- Disability benefits are provided through your employer.
- Member must submit proof to the Benefit Fund that disability benefits have been received to maintain your health coverage for up to 26 weeks.
- Follow the same procedure if you are receiving Workers' Compensation. If you need help or advice in filing a Workers' Compensation claim, call the Benefit Fund at (646) 473-9200.

LIFE INSURANCE

Member-Only Benefit

- Eligibility Class I – During your first year of service, benefit is \$2,000. After your first year, based on your years of service and annual earnings up to a maximum of \$25,000.
- Eligibility Class II – During your first year of service, benefit is \$1,250. Maximum benefit amount is \$2,500.
- Eligibility Class III – Maximum benefit amount is \$1,250.

ACCIDENTAL DEATH AND DISMEMBERMENT

Member-Only Benefit

- For accidental death or injury
- Equal to, or one-half of, your life insurance

BURIAL

Eligibility Class I: Member and Spouse

Eligibility Class II: Member Only

Eligibility Class III: Not covered

- Free burial plot with permanent care
- Plots located in New York and New Jersey

LEGEND

Member: You, the member

Spouse: Your spouse, if eligible

Children: Your children, if eligible

Family: You, your spouse and your children, if eligible

COVERAGE**IN-NETWORK BENEFITS ONLY****MENTAL HEALTH SERVICES****Inpatient**

Limited to 30 days per contract year

The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.

Outpatient

Limited to 30 visits per contract year

The member cost-sharing applies to all covered benefits incurred during a member's outpatient visit.

Maximums are combined for mental health and alcohol/drug abuse services.

- Covered 85% after deductible is met
- \$10 co-pay

ALCOHOL/DRUG ABUSE SERVICES**Inpatient**

Limited to 30 days per contract year

The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.

Outpatient

Limited to 60 visits per contract year.

The member cost-sharing applies to all Covered Benefits incurred during a member's outpatient visit.

Maximums are combined for mental health and alcohol/drug abuse services.

- Covered 85% after deductible is met
- \$10 co-pay

OTHER SERVICES**Convalescent Facility**

Limited to 60 visits per contract year

The member cost-sharing applies to all covered benefits incurring during a member's inpatient stay.

Home Health Care

Includes private duty nursing

Each visit by a nurse or therapist is one visit.

Each visit up to four hours by a home health care aide is one visit.

Hospice Care – Inpatient

The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.

Hospice Care – Outpatient

The member cost-sharing applies to all covered benefits incurred during a member's outpatient visit.

- Covered 85% after deductible is met
- Covered 85% after deductible is met
- Covered 85% after deductible is met
- Covered 85% after deductible is met

COVERAGE**IN-NETWORK BENEFITS ONLY****Outpatient Short-Term Rehabilitation**

Includes speech, physical, and occupational therapy, limited to 20 visits per contract year

Spinal Manipulation Therapy**Durable Medical Equipment**

Maximum annual benefit of \$700 per member per contract year

Diabetic Supplies**Contraceptive Drugs and Devices Not****Obtainable at Pharmacy**

(includes coverage for contraceptive visits)

Transplants

Coverage is provided at an IOE-contracted facility only (\$10,000 travel max).

Mouth, Jaws and Teeth**Vision**

- \$10 co-pay
- \$10 co-pay
- Covered 85% after deductible is met
- Covered as any other medical expense
- Covered 85% after deductible is met. Payable as any other covered expense.
- Covered 85% after deductible is met. Payable as any other covered expense.
- Member cost-sharing is based on the type of service performed and the place of services where it is rendered.
- One pair of glasses every 24 months, including contact lenses
- Reimbursement to the member upon receipt of a claim
- \$125 allowance once every 24 months

FAMILY PLANNING**Infertility Treatment****Voluntary Sterilization**

Including tubal ligation and vasectomy

- Not Covered
- Member cost-sharing is based on the type of service performed and the place of service where it is rendered.